STATE OF CALIFORNIA

CLAIM FOR REIMBURSEMENT

STD 27A (REV. 9-95) FMC

NOTICE: EVERY PERSON WHO, WITH INTENT TO DEFRAUD, PRESENTS FOR ALLOWANCE OR FOR PAYMENT TO ANY STATE BOARD OR OFFICER . . . AUTHORIZED TO ALLOW OR PAY THE SAME IF GENUINE, ANY FALSE OR FRAUDULENT CLAIM, BILL, ACCOUNT, VOUCHER, OR WRITING, IS GUILTY OF A CRIME (PENAL CODE SECTION 72).

See the instructions on the reverse side before completing this form.

STATE AGENCY NAME	CLAIM AMOUNT $
MAILING ADDRESS	
DEBTOR(S) NAME(S)	DEFICIENT FUND OR ACCOUNT (*Specific title)*
	BUDGET ACT ITEM FROM WHICH TO PAY CLAIM

EXPLANATION OF FACTS *(Including date, place and complete circumstances)*

CORRECTIVE ACTIONS TAKEN

SUMMARY OF SHORTAGE

(Please mark appropriate boxes)

- ☐ Shortage result of uncollectiblle account receivable
  - ☐ Account receivable collection procedures were utilized (SAM 8776.6 - 8776.7)
  - ☐ Attempt made to offset receivable against money owed to person or entity (SAM 8790)
  - ☐ Checkout procedure in effect (SAM 8580.4)
  - ☐ Receivable is a salary/travel advance for a former State employee
    - ☐ Computation of advance complies with SAM 8595
- ☐ Shortage result of theft
  - ☐ Police report
  - ☐ Custodian used due diligence and followed good practices in handling and safeguarding the money
  - ☐ Cash shortage did not result from employee's dishonest, carelessness or negligence
- ☐ Shortage result of clerical error *(Note that explanation must be signed by the person responsible for the error)*
- ☐ Copy of original check *(both sides) is attached (Note that copy of check is required by the State Controller's Office for all claims)*

Based on internal audit unit review, the above information is accurate and complete.

SIGNATURE	TITLE	DATE SIGNED

IF THIS CLAIM IS BEING SUBMITTED AT THE DIRECTION OF THE DEPARTMENT OF FINANCE FOLLOWING AN AUDIT, PLEASE CITE THE AUDIT REPORT NUMBER:

CHIEF ACCOUNTING OFFICER *(Signature)*	TITLE	TELEPHONE NUMBER	DATE SIGNED
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STATE OF CALIFORNIA
CLAIM FOR REIMBURSEMENT
STD 27A (REV. 9-95) (REVERSE) FMC

INSTRUCTIONS

- This form must be completed with ***all*** of the information required.

- Use this form only for the proposed replenishment of a cash deficiency in an established fund balance *(e.g., office revolving fund, emergency purchase fund, depositor's trust fund, or cashier's change fund or cashier's change fund).*

- ***FOR UNCOLLECTIBLE ACCOUNTS RECEIVABLE,*** **use form STD. 27, Discharge From Accountability, refer to State Administrative Manual Section 8776.6, and submit the form to the *STATE CONTROLLER'S OFFICE*.**

- After completion, submit this form to:

  Department of Finance
  ORF Reimbursement
  Office of State Audits and Evaluations
  915 L Street, 6th Floor
  Sacramento, CA 95814-4998
  IMS Code A-15
  (916) 322-2985 or CALNET 492-2985